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April 6, 2018

Ajit Pai, Chairman
Federal Communications Commission
445 12th Street SW
Washington, DC 20554

RE: Request for Waiver of USAC Funding Cap for 2017 Funding

Dear Mr. Pai,

Please find enclosed for filing, on behalf of our client, Council of Athabascan Tribal Governments ("CATG"), a Request for Review to the Commission requesting full waiver of the Commission's regulatory funding cap on the Universal Service Fund Rural Health Care program and its application to CATG by the Universal Service Administrative Company ("USAC").

On March 16, 2018, CATG received a funding commitment letter from USAC stating CATG's 2017 funding would be reduced by a proration of 84.40458%. CATG was substantially impacted by this denial of 2017 funding. The proration by USAC will result in an increase in cost of more than $470,000 to CATG.

We request that the Commission issue a written decision in response to this request within 90 days pursuant to 47 C.F.R. 54.724(b).

Thank you for your consideration of this matter.

Sincerely,

HOBBS, STRAUS, DEAN & WALKER, LLP

By: Geoffrey Strommer by CAG
Geoffrey D. Strommer

CC: Charleen Fisher, Executive Director, CATG
Universal Service Administrative Company, Rural Health Care Division

Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554

In the Matter of	)	
	)	
Request for Review by	)	WC Docket No. 02-60
Council of Athabascan Tribal Governments	)	
of Decision of	)	
Universal Service Administrator	)	
	)	
HCP No. 11023	)	
	)	

FCC WAIVER REQUEST MADE BY COUNCIL OF ATHABASCAN TRIBAL GOVERNMENTS

The Council of Athabascan Tribal Governments ("CATG") hereby requests that the Federal Communications Commission ("FCC" or "Commission") waive the application of its regulation found at 47 C.F.R. § 54.675(a) ("Regulatory Cap") which imposes a cap of $400 million on Universal Service Fund ("USF") funding for the Rural Health Care ("RHC") program. This waiver is required by the Telecommunications Act of 1996 ("Act"), which mandates full funding of the RHC program. CATG further requests that FCC reverse the recent decisions of the Universal Services Administrative Company ("USAC" or "Administrator") made in Funding Commitment Letters ("FCLs") issued March 16, 2018 to CATG[1] to partially deny 2017 Funding Year ("FY 2017") RHC funding to CATG due to demand exceeding the Regulatory Cap.

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[1] As of the date of this filing, USAC has not responded to all of CATG's FY 2017 funding requests. CATG will supplement this Waiver Request when it has received the outstanding FCLs. Nonetheless, the substantial impact of the proration decision is known and ripe for review. CATG has received only one FCL in response to its Form 461 Application for funding under the RHC Healthcare Connect Fund (attached as Exhibit B). CATG also applied for funding pursuant to the RHC Telecommunications Fund and has received no FCLs in response to those applications.

I. Introduction and Background

The Council of Athabascan Tribal Governments ("CATG") provides health care services to Alaska Natives and other beneficiaries pursuant to the Alaska Tribal Health Compact ("ATHC"), a multi-party self-governance agreement between the United States Indian Health Service ("IHS") and Alaska Tribes and Tribal organizations under Title V of the Indian Self-Determination and Education Assistance Act ("ISDEAA"), 25 U.S.C. § 5381, *et seq*. The ATHC authorizes its co-signers, such as CATG, to provide health care services to IHS beneficiaries and others pursuant to the terms of the ATHC and Funding Agreements ("FA") with the IHS.

CATG operates clinics in the extremely remote Yukon Flats region of Alaska, serving Alaska Natives and others in remote and sparsely populated villages. For most of these villages, many of which are accessible only by air, CATG's clinics provide the only health care services available. CATG relies heavily on telemedicine to provide services to these villages. The extreme remoteness of these clinics results in punishingly high costs of infrastructure for internet connectivity required for telemedicine, electronic health records and other mission critical services, and CATG depends on the reimbursement provisions of the Universal Service Fund Rural Health Care program to pay for these costs.

On March 16, 2018, USAC responded to CATG's Funding Requests ("FR") with Funding Commitment Letters ("FCL") that reduced the funding to which CATG is entitled by a proration of 84.40458%. This funding denial in the form of a proration, when applied to each of CATG's FRs, will total more than $473,000 of lost funding in funding year 2017. USAC's denial has created an emergency budget situation for CATG that, without the FCC's granting of the relief sought here, will lead to program cuts, layoffs, and a disruption of mission critical services

that will unquestionably result in injury and loss of life within the eligible populations served by CATG.

In funding year 2017, CATG, along with other rural Health Care Providers ("HCPs"), received a similar but lower proration of their funding year 2016 FRs, also on the basis of the Regulatory Cap. CATG appealed to USAC to review and reverse the funding year 2016 FCL funding denial. That appeal, filed on June 12, 2017, was never addressed by USAC.[2]

The FCC and USAC erred in applying an across-the-board *pro rata* reduction in RHC funding due to the $400 million Regulatory Cap that the Commission arbitrarily imposed, thus eliminating any opportunity for full funding for the services CATG requested in its Form 461, Form 462, Form 465 and Form 466 funding requests. Neither USAC nor FCC has determined that CATG failed to meet all requirements of the RHC funding mechanism, and USAC was therefore statutorily required to commit funding for the Funding Requests summarized in Exhibit A.

CATG hereby requests that FCC waive the application of the Regulatory Cap to CATG's funding year 2017 FRs, direct the USAC Rural Health Care (RHC) Division to vacate its decisions to deny funding for the FRs referenced in Exhibit A, and fully fund CATG's funding year 2017 FRs.

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[2] USAC never responded to CATG's funding year 2016 appeal. The FCC issued a waiver that allowed the telecommunications carriers providing services funded by the RHC program to waive, or forgive, the difference between the "total funding amount" and the "committed," or prorated, funding amount. *See* Rural Health Care Support Mechanism, WC Docket No. 02-60, Order, 32 FCC Rcd. 5463, 5465, para. 9 (2017) ("Alaska Waiver Order"). This is not a sustainable solution, and CATG and other tribal health providers cannot rely on such losses being absorbed by the carriers in the future.

II. Statement of Interest

CATG appeals to the Commission pursuant to 47 C.F.R. § 54.719(c), which provides that "Parties seeking waivers of the Commission's rules shall seek relief directly from the Commission." The FCC promulgated the Regulatory Cap on March 1, 2013. 78 Fed. Reg. 13,992 (codified at 47 C.F.R. § 54.675). USAC has no authority to waive an FCC regulation.[3] 47 C.F.R. § 54.702(c). However, FCC regulations expressly provide that the Commission may waive any provision of its rules "if good cause therefor is shown." 47 C.F.R. § 1.3. Because the FCC, and not USAC, has authority to waive FCC's Regulatory Cap on the basis that the cap is beyond the authority delegated by Congress in the Telecommunications Act, the Commission has sole jurisdiction over this appeal. Further, because the legal issue underlying this appeal – the legality of the Regulatory Cap pursuant to the Telecommunications Act – "involves novel questions of fact, law, or policy," CATG is entitled to review by the full Commission. 47 C.F.R. § 54.722(a).

This appeal is timely filed within sixty days of the USAC decision in the March 16, 2018 CATG FY 2017 Funding Commitment Letters. 47 C.F.R. § 54.720.

III. Statement of Facts

The CATG Form(s) referenced in Exhibit A were timely submitted on behalf of CATG to fund the provision of services at clinics that provide health care for CATG member Tribes' populations as well as other eligible beneficiaries.

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[3] 47 C.F.R. § 54.702(c) states, "The Administrator may not make policy, interpret unclear provisions of the statute or rules, or interpret the intent of Congress. Where the Act or the Commission's rules are unclear, or do not address a particular situation, the Administrator shall seek guidance from the Commission."

On March 16, 2018, FY 2017 FCLs were issued by USAC. In those FCLs, USAC, repeating its distinction first made in the FY 2016 FCLs, distinguished between the "Total Funding Amount" and the "Committed Funding Amount*". The note indicated by USAC's asterisk stated the following: "The pro-rata factor for this filing window period is 84.40458%."

USAC approved funding for CATG through the FCLs at the rate of 84.40458% of the amount requested, resulting in the denial of funding for the underlying funding requests in an amount of at least $473,000. The exact amount will be determined once all the FCLs are received. The application of a *pro rata* percentage of funding by USAC constituted a partial denial of funding, even if USAC does not characterize the proration as a funding denial.

Exhibit A lays out in detail each of the three CATG FRs for which CATG has received an FCL to date for funding year 2017. Exhibit A provides the Service Provider, Health Care Provider, Form 461/465 Application Numbers, Funding Request Numbers, and total funding requested and approved by USAC, as well as the total "Committed Funding Amount" by USAC, which reflects the application of the *pro rata* formula, received by CATG as of the date of this filing. Exhibit B contains the FCLs received thus far themselves.

CATG's funding requests and the total funding amounts approved by USAC comply with applicable law and the FCC's requirements, but the arbitrarily created category of "Committed Funding," based upon a *pro rata* formula implementing the Regulatory Cap, is contrary to applicable law and policy.

IV. Question Presented for Review

Does the Commission's Regulatory Cap at 47 C.F.R. § 54.675, which imposes a $400 million funding cap on the Universal Service Fund Rural Health Care program, and USAC's application of the cap by prorating CATG's mandatory funding requests, exceed the authority

delegated to the Commission by Congress pursuant to the Telecommunications Act of 1996, 47 U.S.C. § 254?

V. Discussion

FCC and USAC impermissibly acted beyond the boundaries of statutory and congressionally delegated authority when FCC promulgated the Regulatory Cap and USAC prorated CATG's statutorily required funding. The Regulatory Cap violates the Telecommunications Act, the FCC's own 1997 Universal Service Order, and the trust responsibility of the federal government to provide health care to American Indians and Alaska Natives, as articulated by the FCC in its 2000 Tribal Policy Statement.

The Telecommunications Act of 1996, 47 U.S.C. § 254

Section C of the Telecommunications Act is written unambiguously as a mandatory program that includes USF funding as an entitlement associated with that mandate. Under Section 254(h)(1)(A), Congress required carriers to provide rural HCPs necessary services at rates comparable to urban areas, and, in turn, required the FCC to reimburse carriers on behalf of rural HCPs:

> A telecommunications carrier shall, **upon receiving a bona fide request**, provide telecommunications services which are necessary for the provision of health care services in a State, including instruction relating to such services, to any public or nonprofit health care provider that serves persons who reside in rural areas in that State at rates that are reasonably comparable to rates charged for similar services in urban areas in that State. A telecommunications carrier providing service under this paragraph **shall be entitled to have an amount equal to the difference**, if any, between the rates for services provided to health care providers for rural areas in a State and the rates for similar services provided to other customers in comparable rural areas in that State **treated as a service obligation as a part of its obligation to participate in the mechanisms to preserve and advance universal service.**

47 U.S.C. § 254(h)(1)(A) (emphasis supplied).

Examination of the plain language of the Act, and its use of the word "shall" in the operative phrase that carriers "shall be entitled to have an amount equal to the difference" between rates reveals that USF payments to the carriers by USAC are mandatory, not optional. "[T]he starting point for interpreting a statute is the language of the statute itself. Absent a clearly expressed legislative intention to the contrary, that language must ordinarily be regarded as conclusive." *O'Hara v. Teamsters Union Local No. 856*, 151 F.3d 1152, 1160 (9th Cir. 1998) (*quoting Continental Cablevision, Inc. v. Poll*, 124 F.3d 1044, 1048 (9th Cir.1997)). Congress' use of "shall" in the statute signals a mandatory command to the FCC and USAC. *Ass'n of Civilian Technicians, Montana Air Chapter No. 29 v. Fed. Labor Relations Auth.*, 22 F.3d 1150, 1153 (D.C. Cir. 1994) ("The word "shall" generally indicates a command that admits of no discretion on the part of the person instructed to carry out the directive")(emphasis supplied).

FCC Regulation 47 C.F.R. § 54.675 – The Regulatory Cap

Despite the Act's statutory mandate, FCC departed from the statute in implementing 47 C.F.R. § 54.675 in two ways that injured CATG and similarly situated HCPs. First, the regulation imposed a $400 million Regulatory Cap on the amount available for the program, with no statutory support and in derogation of the Act's funding mandate, creating an artificial shortfall and injuring the HCPs. Second, Section 54.675 impermissibly realigned the statutory relationships between the Administrator, HCPs and carriers to force the HCPs, rather than the carriers, to bear the burden of that shortfall.

When an agency acts "beyond the bounds of its statutory authority," it is not entitled to deference. *Pharm. Research & Manufacturers of Am. ("PHRMA") v. United States Dep't of Health & Human Servs.*, 43 F. Supp. 3d 28, 40 (D.D.C. 2014). "It is axiomatic that an administrative agency's power to promulgate legislative regulations is limited to the authority

delegated by Congress." *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208 (1988). "No matter how it is framed, the question a court faces when confronted with an agency's interpretation of a statute it administers is always, simply, whether the agency has stayed within the bounds of its statutory authority." *PHRMA,* 43 F. Supp. 3d at 36 (*quoting City of Arlington, Tex. v. F.C.C.*, 569 U.S. 290, 295 (2013)).

FCC's rulemaking authority in this case is limited to making changes in FCC regulations implementing the requirements of 47 U.S.C. § 214(e), which governs the USF program.[4] That authority does not extend to restricting funding to rural HCPs with an annual $400 million cap or requiring *pro rata* distribution of funds to applicants if the cap is exceeded.

In *In Re FCC 11-161*, the Court of Appeals for the Tenth Circuit considered various challenges to the FCC's rulemaking related to the USF. *In re FCC 11-161*, 753 F.3d 1015 (10th Cir. 2014). The majority of that Tenth Circuit panel deferred to the FCC in each challenge on the basis that Congress had delegated broad authority in the matters raised by petitioners, reasoning that the Telecommunications Act used broad language and left statutory gaps for the FCC to fill.[5]

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[4] That rulemaking authority in 47 U.S.C. § 254(a) requires the FCC, in accordance with recommendations of a Federal-State Board, to change FCC regulations in order to implement § 214(e) of the Act. Section 214(e)(1) governs the provision of universal service by: (1) designating common carriers which shall be eligible to receive universal service support under § 254; (2) defining the services that will be supported by Federal universal service support mechanisms under § 254(c); and (3) advertising the availability of such services and the charges therefor using media of general distribution. Section 214(e)(2) governs designation of eligible telecommunications carriers by State commissions. Section 214(e)(3) governs designation of eligible telecommunications carriers for un-served areas.

[5] See *In Re FCC 11-161*, 753 F.3d at 1120 ("Congress appears to grant plenary authority to the FCC through § 251...."); *id* at 1046 ("nothing in the language of subsection (c)(1) serves as an express or implicit limitation on the FCC's authority to determine what a USF recipient may or must do with those [USF] funds."), *id.* ("as the FCC suggests, it is reasonable to conclude that Congress left a gap to be filled by the FCC, i.e., for the FCC to determine and specify precisely how USF funds may or must be used.), *id.* at 1047 ("Because Congress instead chose to utilize broader language, it was certainly reasonable for the FCC to have concluded

However, none of the petitioners in that matter brought the specific challenge raised here – that the FCC acted outside of the scope of 47 U.S.C. § 254(h)(1)(A) when it issued a regulation imposing a Regulatory Cap on the Rural Health Care program. FCC may not claim "plenary authority to act within a given area simply because Congress has endowed it with some authority to act in that area." *Am. Library Ass'n. v. F.C.C.*, 406 F.3d 689, 708 (D.C. Cir. 2005).

Congress did not use broad language or leave a statutory gap in its provisions creating the support entitlement under the Rural Health Care program. Section 254(h)(1)(A)'s use of the mandatory language "shall" and "entitled" distinguishes the language establishing the Rural Health Care program from other provisions in the Act that conferred broader authority on the FCC. The majority in *In Re FCC 11-161* noted that Congress' use of the word "shall" in Section 254(b) of the Act "indicates a mandatory duty on the FCC" and limited the agency's discretion,[6] stating that "FCC may exercise its discretion to balance the principles [in § 254(b)] against one another when they conflict, but may not depart from them altogether to achieve some goal." *In Re 11-161*, 753 F.3d at 1055 (emphasis supplied) (quoting *Qwest Corp. v. F.C.C.*, 258 F.3d 1191, 1200 (10th Cir. 2001)).

The regulation at 47 C.F.R. § 54.675 was a wholesale departure from the statutory language of Section 254(h)(1)(A), which provides that telecommunications carriers "shall" provide services to rural HCPs upon request and "shall be entitled" to have the specified rate differential "treated as a service obligation as part of its obligation to participate in the

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that the language was intended as an implicit grant of authority to the FCC to flesh out precisely what "facilities" and "services" USF funds should be used for.").

[6] 47 U.S.C. § 254(b) states, "[t]he Joint Board and the Commission shall base policies for the preservation and advancement of universal service on [various enumerated principles]").

mechanisms to preserve and advance universal service," without limitation. The FCC identified no statutory authority to impose the Regulatory Cap on this program, and failed to explain why $400 million was an appropriate limit on distribution of the USF funds entrusted to USAC. The preamble in the Federal Register publishing the final regulation on March 1, 2013 (78 FR 13936) lacks any substantive discussion of the origin or reason for the cap, which is remarkable for such a major administrative departure from the statute. Regardless of FCC's goal in creating the Regulatory Cap, such a departure from the clear mandatory statutory language lies beyond the FCC's authority to implement Congress' mandate.

Further, the FCC's regulation at 47 CFR § 54.675 requires the HCPs, rather than the carriers to whom the entitlement is owed, to request funding from the FCC Administrator. The result is that the burden of any shortfall in RHC funding falls on the HCPs rather than the carriers. The Act, however, requires only that health care providers make a "bona fide request" for service to the carriers, and then requires that the carriers provide the requested service at certain rates. 47 U.S.C. § 254(h)(1)(A)("A telecommunications carrier shall, upon receiving a bona fide request, provide telecommunications services which are necessary for the provision of health care services in a State."). The statute does not permit the FCC to impose a financial burden on the HCPs by limiting the amount of RHC funding available and then shifting the burden of that limited funding from the carriers to the HCPs. The FCC regulations do both, and are thus contrary to statute and in excess of the FCC's statutory authority.

In short, the Telecommunications Act includes a mandatory directive to ensure that rural healthcare providers, including Indian tribes and tribal health organizations, pay no more than their urban counterparts. 47 U.S.C. § 254(h)(1)(A). The FCC and the USAC may not ignore that statutory mandate by invoking a regulatory cap on payments. *See, e.g., Salazar v. Ramah Navajo*

Chapter, 567 U.S. 182 (2012) (statute requires full payment of tribal organization's "contract support costs" despite spending caps). In *Ramah*, the Supreme Court held that full payment of indirect costs to Indian tribes was required, even though the governing law stated that "the provision of funds under this chapter is subject to the availability of appropriations...." 25 U.S.C. § 5325. The Telecommunications Act does not condition USF funds (which are collected from service providers and not appropriated by Congress) on availability, but simply provides that carriers providing service to rural HCPs "shall be entitled" to the rate differential. FCC has made no claim that the USF cannot completely fulfill the entire demand for Rural Health Care program funds, and even if such a shortfall existed, its obligation to CATG and the carriers that serve CATG would continue.[7]

1997 FCC Universal Service Order

Following the passage of the Telecommunications Act in 1997, and during the implementation phase of the RHC funding, the FCC issued a Report and Order "In the Matter of Federal-State Joint Board on Universal Service" (hereafter "*FCC Universal Service Order*"), FCC Docket No. 96-45 (May 8, 1997). In the Order, the FCC agreed that the RHC funding was not a discretionary grant program, and that the Telecommunications Act created a right to federal funding:

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[7] See also *Cherokee Nation of Okla. v. Leavitt*, 543 U.S. 631, 637 (2005)("[the] Government normally cannot back out of a promise on grounds of 'insufficient appropriations,' even if the contract uses language such as 'subject to the availability of appropriations,' and even if an agency's total lump-sum appropriation is insufficient to pay all the contracts the agency has made."); see also *Ferris v. United States*, 27 Ct. Cl. 542, 546 (1892) (insufficiency of an appropriation does not cancel the obligations of the federal government).

> Section 254(h)(1)(A) grants the right to receive federal universal service support to "any public or non-profit health care provider that serves persons who reside in rural areas of that state."

FCC Universal Service Order at 335-36 (emphasis supplied).

This language is clear on its face: the FCC acknowledged that RHC funding is mandatory and that the Act creates a right to receive these services. Despite this clear mandate, and instead of structuring the program at the outset as a program with mandatory funding obligations that spring from the statute itself, the FCC arbitrarily established a $400 million cap on RHC funding to the HCPs, which led to the current shortfall. It did so not because it was directed to by Congress, or because the initial Joint Board suggested a cap, but instead to "be specific, predictable, and sufficient." *FCC Universal Service Order* at 365.

The Regulatory Cap had not affected CATG or similarly situated rural HCPs until recently because USAC was able to accommodate all funding requests and needs within the capped funds. In 2016, however, the Regulatory Cap was exceeded for the first time because of increasing program utilization. If the initial $400 million cap had been increased in pace with inflation since 1997, it should now (at a minimum) be funded at $571 million based on the GDP-CPI.[8] Despite the increased need, the FCC has kept the $400 million cap in place in violation of its statutory obligations to fully fund all "bona fide" service requests.

It is telling that, when it established the cap, the FCC did not anticipate that it would be reached. In the FCC Universal Service Order, the FCC found that the cap was only intended to provide a specific amount to Congress, not to require a *pro rata* formula for distribution. The FCC stated, "[w]e estimate that the maximum cost of providing services eligible for support

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[8] Notice of Proposed Rulemaking and Order, FCC 17-164, ¶ 16 (December 18, 2017).

under section 254(h)(1)(A) is $366 million, if all eligible health care providers obtain the maximum amount of supported services to which they are entitled." *FCC Universal Service Order* at 366 (emphasis supplied). In the Preamble to its rulemaking creating the Regulatory Cap, less than five years ago, the FCC argued that the "cap" itself was of no concern, from an apportionment of funding perspective, since the FCC had no reason to think it would ever be reached: "Given the historical utilization of RHC support and the implementation timetable for funding year 2013, we do not currently anticipate that demand will exceed the $400 million cap in FY 2013 or for the foreseeable future." 78 Fed. Reg. 13,964 (March 1, 2013).

The fact that the FCC has recognized the right of HCPs to receive these services, as well as the fact that the FCC never intended the Regulatory Cap to impact the program (because the FCC did not believe that the cap would be reached) support waiver in this instance. The Regulatory Cap is now impacting the right and ability of CATG to access mission critical services while maintaining the integrity of its health care programs in extremely isolated, rural areas of Alaska. In addition to violating statutory mandates, application of the Regulatory Cap is not in line with the FCC's own policies and priorities as recognized in the 1997 FCC Universal Service Order and elsewhere.

Federal Trust Responsibility and the 2000 FCC Tribal Policy Statement

Federal law and FCC policy provide additional justifications for waiver of the cap as it impacts CATG specifically. CATG is a regional organization formed by sovereign Alaska Native tribes, each of which is federally recognized by the United States Department of the Interior. As such, the provision of health care by CATG in the Yukon Flats region is a part of the federal trust responsibility to Tribes, Alaska Native villages, and their members.

Inherent tribal sovereignty predates the formation of the federal government of the United States as well as, in the State of Alaska, the onset of statehood in the territory. In the early days of the United States, the Supreme Court issued decisions defining important aspects of the relationship of sovereign tribal nations to the federal government. In *Cherokee Nation v. Georgia*, Chief Justice Marshall noted the special duty the federal government assumed in its dealings and agreements with American Indians. *Cherokee Nation v. Georgia*, 30 U.S. 1 (1831). Marshall identified Indian Tribes as "domestic dependent nations" and observed that the relationship between Indians and the federal government was like that "of a ward to his guardian." *Id.* The following year, the Supreme Court in *Worchester v. Georgia* established that the federal government, not states, has the authority over and responsibility for matters relating to members of Indian Tribes. *Worcester v. Georgia*, 31 U.S. 515 (1832).

As the relationship with Indian Tribes and Alaska Natives moved into the twentieth century, this broad concept of the federal "trust responsibility" was reinforced by Congress in statute. In the area of healthcare, Congress passed the Snyder Act in 1921, providing explicit federal authorization supporting health programs for Indians and Alaska Natives by mandating the expenditure of funds for "[t]he relief of distress and conservation of health ... [and] for the employment of ... physicians ... for Indian tribes." 25 U.S.C. § 13.

Congress revisited the trust responsibility for tribal and Alaska Native health care in 2010 with passage of the Indian Health Care Improvement Act, in which the federal government found that "[f]ederal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people." 25 U.S.C. § 1601(1). Congress also found that it is a "[m]ajor national goal . . . to provide the resources, processes, and structure that

will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States." 25 U.S.C. § 1601(2).

It is against this backdrop of the federal trust responsibility to provide health care services to Tribes and Alaska Native villages that the FCC's responsibility to support the mission critical aspects of CATG's rural health care system must be understood. The FCC took up the matter of its own relationship with Tribes and Alaska Natives in June 2000 with its Policy Statement entitled "In the Matter of Statement of Policy on Establishing a Government-to-Government Relationship with Indian Tribes."[9] In that Policy Statement, the FCC stated that "[t]he federal government has a federal trust relationship with Indian Tribes, and this historic trust relationship requires the federal government to adhere to certain fiduciary standards in its dealings with Indian Tribes." *FCC Policy Statement* at 3.

To implement this trust responsibility, the FCC committed to "[w]ork with Indian Tribes on a government-to-government basis consistent with the principles of Tribal self-governance to ensure, through its regulations and policy initiatives ... that Indian Tribes have adequate access to communications services." *Id.* at 4. The FCC also committed that the agency, "[i]n accordance with the federal government's trust responsibility, and to the extent practicable, will consult with Tribal governments prior to implementing any regulatory action or policy that will significantly or uniquely affect Tribal governments, their land and resources." *Id.* Further, the FCC would "endeavor to streamline its administrative process and procedures to remove undue burdens that its decisions and actions place on Indian Tribes." *Id.* at 5.

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[9] Available at https://www.fcc.gov/Bureaus/OGC/Orders/2000/fcc00207.doc (last accessed March 21, 2018).

The CATG is a co-signer of the ATHC and has, over the years, entered into multiple FAs with the IHS through which it has assumed the United States' responsibility to provide health care to beneficiaries and others in the Yukon Flats region. In delivering these responsibilities in the region, CATG has come to rely upon RHC funding through the USF to ensure that mission critical connectivity is available, without which CATG's ability to provide these federal programs and the federal trust responsibilities would be significantly impacted. CATG, in turn, relies on the FCC to implement federal law and regulations related to RHC funding and implementation in a manner that is supportive of the trust responsibility as well as the contractual obligations between CATG and the United States.

In this case, the term "shall be entitled" in § 254(h)(1)(A) is unambiguous, and creates a mandatory funding entitlement. Additionally, however, the FCC's obligation is reinforced by its practice of interpreting questionable terms in favor of federally recognized Tribes such as CATG's members "[i]n light of the goal of the rural health care universal service provision...and consistent with the federal trust relationship between the federal government and federally-recognized Indian tribes." *FCC Order in the Matter of Requests for Review of the Decisions of the Universal Service Administrator by Kawerak, et. al.*, 18 FCC Rcd. 18767 (2003). Consequently, even assuming that the phrase "shall be entitled to have an amount equal to the difference" between rates is ambiguous, any ambiguity must be resolved in favor of the tribal interests involved. "[S]tatutes are to be construed liberally in favor of the Indians, with ambiguous provisions interpreted to their benefit." *Montana v. Blackfeet Tribe of Indians*, 471 U.S. 759, 766 (1985).

VI. Relief Sought

The USAC now administers almost $10 billion annually in the Universal Service Fund.[10] Funding for broadband-enabled health care is needed today more than ever, and the $400 million Regulatory Cap established by the FCC was not consistent with the statutory language mandating full RHC funding.

The FCC, in denying tribes and tribal health organizations like CATG full funding for these mission critical services, has violated the Telecommunications Act, the FCC's own Tribal Policy Statement, and the trust responsibility of the federal government to provide health care to American Indians/Alaska Natives. The burgeoning demand for Universal Service Fund Rural Health Care funds in funding year 2016 and funding year 2017 demonstrates clearly that this arbitrary cap is no longer sufficient.

For the foregoing reasons, CATG requests that the FCC waive application of 47 C.F.R. § 54.675 and direct the USAC RHC staff to commit full funding for all of CATG's funding year 2017 funding requests without proration.

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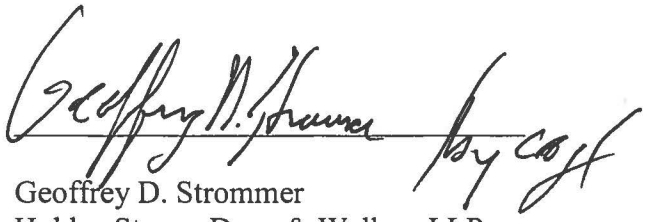
[10] USAC website, http://www.usac.org/about/default.aspx (last accessed March 21, 2018).

Respectfully Submitted,



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On behalf of
Council of Athabascan Tribal Governments

EXHIBIT A

FUNDING REQUESTS AND COMMITTED FUNDING FOR CATG

Table 1 – Funding Requests and Committed Funding for CATG

FY 2017 BB						
Service Provider and SPIN Number	**Health Care Provider (HCP) and HCP Number**	**Form 461 / Form 465 Application Number**	**Funding Request Number (FRN)**	**Total Funding Amount (monthly)**	**Committed Funding Amount from USAC**	**Amount in Dispute Due to Pro Rata Distribution**
GCI Communication Corp 143001199	Yukon Flats Health Center / 11023	Form 461 No. 100019435	17140321	$8,016.39	$6,766.20	$1,250.19
					Total:	**$1,250.19**

EXHIBIT B

USAC FUNDING COMMITMENT LETTER(S)

Funding Commitment Letter Date:	3/16/2018
Invoicing Deadline:	12/31/2020

Funding Year:	2017
Health Care Provider (HCP) Name:	Council of Athabascan Tribal Governments-Yukon Flats Health Center
HCP Number:	11023
HCP Contact Name:	Matt Reppel
HCP Contact Email:	matt.reppel@catg.org
HCP Contact Phone:	(907) 662-7514
FCC Form 461 Application Number:	100019435
Funding Request Number:	17140321

The Rural Health Care (RHC) division of the Universal Service Administrative Company (USAC) has completed its review of the FCC Form 462 *Healthcare Connect Fund Funding Request Form* (Form 462) and the supporting information submitted by the HCP named above. Based on the information provided, RHC has determined that the HCP is eligible for the funding estimated below. It is the HCP's responsibility to review this FCL and verify that all information is accurate.

Total Committed Funding:	$6,766.20
HCP Physical Location:	E. 3rd & Birch Street, Fort Yukon, AK 99740
Service Type:	Internet
Bandwidth:	30.0MB / 30.0MB
Service Provider Name:	GCI Communication Corp
Service Provider Identification Number (SPIN):	143001199
Billing Account Number (BAN):	RH000220016
Contract ID:	935500
Evergreen Determination:	Evergreen
Contract Sign Date:	3/22/2017
Contract End Date:	8/23/2020

Single Expense Information

Funding Start Date	Funding End Date	Undiscounted Recurring Expense	Undiscounted Non-Recurring Expense	Recurring Funding Amount	Non-Recurring	Total Funding Amount	Committed Funding Amount

					Funding Amount		
8/24/2017	6/30/2020	$360.00	$0.00	$8,016.39	$0.00	$8,016.39	$6,766.20

If a multi-year commitment was approved, funding is shown by funding year.
Year One: $2,026.04
Year Two: $2,370.08
Year Three: $2,370.08

The pro-rata factor for this filing window period is 84.40458%.

This funding request was submitted during FY2017 Filing Window 1. All qualifying requests submitted within the filing window period will receive a pro-rated percentage of the total funds available during FY2017 Filing Window 1 based on the total amount of qualifying funding requested during the filing window period. For each filing window period, if the total demand for RHC Program funding exceeds the total remaining funding available for the fund year, USAC will apply a pro-rata factor to each funding request. Learn more about funding request filing window periods here.

About pro-ration:

- If the final total dollar value of all qualifying funding requests exceeds the $400 million cap for all qualifying funding requests by the close of a filing window period, qualifying funding requests submitted during that filing window period will receive a pro-rated percentage of the total funds available during the filing window period.
- If the final total dollar value of all qualifying upfront payments and qualifying multi-year funding requests exceeds $150 million by the close of a filing window period, qualifying upfront payments and qualifying multi-year funding requests will receive a pro-rated percentage of the annual $150 million limit on funding for upfront payments and multi-year funding requests. This annual limit on upfront payments and multi-year payments is included in, and not in addition to, the aggregate $400 million annual cap on all qualifying funding requests. 47 C.F.R. § 54.675 (a)

Evergreen: For the life of the original term of the contract, the HCP is not required to re-complete the service(s) identified above, nor post an FCC Form 461 Healthcare Connect Fund Request for Services Form (Form 461). An HCP that exercises an option to extend the duration of an Evergreen contract may do so without the competitive bidding process for that funding year; however, the option to extend the duration of an Evergreen contract must be memorialized in the terms of the original contract, and the HCP's decision to extend the duration of an Evergreen contract must occur before the HCP submits the Form 462 for the funding year in which the Evergreen contract expires.

Approved multi-year funding requests must have an Evergreen-endorsed contract. Once funding is approved for multi-year funding, the HCP does not have to submit a Form 462 for the service(s) identified above, through the funding end date shown above. An HCP with new services (or upgrades not requested in the original Form 461) must submit a Form 461, and participate in the competitive bidding process, before submitting a Form 462.

Non-Evergreen (Month-to-Month): If an HCP submits a service agreement or contract that is not signed and dated, or if the type of service, the terms of service, or the duration of the service(s) are not specified, the service agreement or contract will be endorsed as Non-Evergreen (month-to-month). If an HCP requests a multi-year commitment, but the submitted contract is endorsed as Non-Evergreen, funding will be provided only for the period within that funding year. In all cases where a contract is endorsed as Non-Evergreen, the HCP must participate in competitive bidding for each funding year that funding is requested. **Reminder:** To be eligible for a full year of funding, the FCC Form 461 Healthcare Connect Fund Request for Services Form (Form 461) must be approved and posted no later than 28 days before the FCC Form 462 is submitted to allow for the required competitive bidding period prior to selecting services.

Your responsibility: It is the HCP's responsibility to review the information in this FCL. Contact RHC at rhc-hcp@usac.org if there is an error with the amount of funding or other information in this FCL.

If, at any time, the funded services are no longer provided to the HCP or the HCP is not otherwise receiving the approved funding, it is the HCP's responsibility to notify RHC immediately.

Information provided on Forms 461, 462, and the FCC Form 463 Healthcare Connect Fund Invoice and Request for Disbursement Form (Form 463) are subject to audit by RHC and the FCC. HCPs are subject to audits and other reviews by USAC and/or the FCC to ensure that the universal service funding is used in compliance with FCC program rules. If USAC discovers that funds are not used in compliance with program rules, an HCP may be subject to enforcement activities and other means of recourse by USAC and other appropriate federal, state, and local authorities.

Next Steps: The HCP must complete and submit the Form 463 through the "My Portal" website. The Form 463 will confirm receipt of the services and equipment for which funding has been approved and the date on which the service provider began providing those services. The service provider will 1) confirm the accuracy of the Form 463; 2) confirm that the HCP has paid its 35% contribution; and 3) submit the Form 463 to RHC for payment.

The Form 463 must be submitted by the date listed at the top of this letter (Invoicing Deadline) which is six months after the end date of the funding commitment. However, HCPs are encouraged to start the invoicing process as soon as services have started and a bill has been received from the service provider.

For a single Funding Year, if the total undiscounted one-time upfront costs for a consortium are more than $50,000 when divided by the total number of eligible HCPs in the consortium, then those one-time upfront costs must be pro-rated over three years.

Receipt of funding commitments is contingent on compliance with all statutory, regulatory, and procedural requirements of the Rural Health Care HCF Program. HCPs that receive funding commitments may be subject to random audits, site visits, and other reviews by USAC to assure that funds have been committed and are used in accordance with all such requirements. USAC

may be required to reduce or rescind funding commitments that were not issued in accordance with such requirements, whether due to action, or inaction, including but not limited to that by USAC, the HCP or the service provider. USAC, and other appropriate authorities (including but not limited to the Federal Communications Commission), may pursue enforcement actions and other means of recourse to collect improperly disbursed funds.

If you wish to appeal this decision, you must file an appeal with USAC within 60 days of the date of this letter. Detailed instructions for filing appeals are available on the USAC website at http://usac.org/about/about/program-integrity/appeals.aspx.

For questions or assistance, or if this email has been received in error, contact Rural Health Care at (800) 453-1546, between 8:00 a.m. and 5:00 p.m. Eastern Time Monday through Friday or by email at rhc-hcp@usac.org.

All account holders and the service provider contact listed on the Form 498 will receive a copy of this FCL.